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PRINTED: 05/07/2007

FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY COMPLETED (X2) MULTIPLE CONSTRUCTIC N (X1) PROVIDER/SUPPLIER/CLIA TATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: A. BUILDING ND PLAN OF CORRECTION B. WING 04/26/2007 09G074 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 4012 LEE STREET, NE WASHINGTON, EC 20019 MT5 PROVIDER'S PLAN OF CORRECTION (X5)SUMMARY STATEMENT OF DEFICIENCIES (EACH COF RECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLÉTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (X4) ID DATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) TAG W 000 INITIAL COMMENTS W 000 This recertification survey was conducted from April 24 through April 26, 2007. The survey was initiated using the fundamental survey process; however, it was determined that the survey should be extended under the condition of participation of Client Frotection. A random sample of two clients was selected from a residential population of three males with various degrees of disabilities. Two of the clients in the facility had psychiatric diagnoses for which medications were prescribed. One client randomly selected at the time of the survey had one to one staffing due to severe seizure activity. The findings of this survey were based on observations at the residence and day program, staff interviews at both the group home and day program, one legal guardian, one family member, review of clinical and administrative records to include the facility's unusual incident reports and policies. From the results of this survey, it was determined that the facility was in compliance with Condition of Participation under Client Protection. 483.420(a)(2) PROTECTION OF CLIENTS W 124 W 124 W124 RIGHTS As indicated by the surveyor, by exit time client #1's The facility must ensure the rights of all clients. brother had signed consent forms for the psychotropic Therefore the facility must inform each client, medication regimen. The QMRP will insure that client parent (if the client is a minor), or legal guardian, #1's brother is informed of any future changes in the of the client's medical condition, developmental psychotropic drug regimen and that he approves them and behavioral status, attendant risks of as evidenced by signed consent forms. The brother has treatment, and of the right to refuse treatment. agreed to be the primary decision making support person for client #1...5-15-07. This STANDARD is not met as evidenced by: (X6) DATE BORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TILE

ny deficiency statement ending with an esterisk (2) denotes a deficiency which the institution may be excused from correcting providing it is determined that ther safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days illowing the date of survey whether or not a plan of correction is provided. For nursing homes, the above find age and plans of correction are disclosable 14 moving the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued ays following the date these documents: are made available to the facility. rogram participation.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 05/07/2007 FORM APPROVED OMB NO. 0938-0391

CONTE	S FOR MEDICAPE	& MEDICAID SERVICES					MID 140. 0930.0381	
WALES		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IULTIPI ILDING	E CONSTRUCTICIN	(X3) DATE SURVEY COMPLETED		
		09G074	B. Wil	NG	· · · · · · · · · · · · · · · · · · ·		04/2	6/2007
	ROVIDER OR SUPPLIER	<b>.</b>	<del></del>	401	ET ADDRESS, CITY, 12 LEE STREET, N	IE: ,	Į	
MTS		·		W/	ASHINGTON, D.C			<u> </u>
(X4) ID PREFIX TAG	ノーえへい かきだいさいだい	FEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SIC IDENTIFYING INFORMATION)	ID PREF TAC	IX	(FACH CORR	R'S PLAN OF CORR RECTIVE ACTION S RENCED TO THE AIDEFICIENCY)	HÖÜLD BE	(76) COMPLETION DATE
W 124	review, the facility of client, parent, or le informed of the clied developmental and risks of treatment, treatment for one of (Client #1)  The finding include the facility falled to informed of the risk	iens, interviews and record failed to ensure that each gally authorized party is ent's medical conditions, it behavioral status, attendant and of the right to refuse of two clients in the sample.  es:  c ensure Client #1 was ks and benefits of his cations and behavior	W	124				
	administration on a review of the Medi (MAR) revealed the 200 mg two (2) take with Registered Not Retardation Professor the client's POs medications were Behavior Manager maladaptive behauted the client #1 had 1:10 the me and at his decrease.	e evening medication April 24, 2007 at 7:13 PM and cation Administration Record nat Client #1 receives Seroquel plets two times a day. Interview urse, Qualified Mental ssional (QMRP) and the review revealed the aforementioned used in conjunction with the ment Plan (BMP) to address viors. At the time of the survey, close supervision in the group any program to protect his health the severity of his selzures.						
	2007 at approximation the life, however, they provide authorizations and management Plain	ed with the QMRP on April 25, ately 3:30 PM revealed that is are actively involved in his are not his legal guardian or tion for medications or Behavior in Further review of the record the OMRP failed to evidence						

that written consent for the use of the

05/16/2007	15:30	FAX	2022448048
05/08/2007	U9:20	LAA	&U44443401

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/07/2007 FORM APPRIOVED OMB NO. 0938-0391

	STATEMENT OF DEFIDIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 1	ULTIPL LDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		09G074	B. WIN	lG			04/2	6/2007
NAME OF PROVIDER OR SUPPLIER M T S				401	ET ADDRESS, CF Y 2 LEE STREET, N SHINGTON, LIC			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFI TAG	x [	(EACH COF:R	'S PLAN OF CORRE ECTIVE ACTION SH ENCED TO THE API DEFICIENCY)	OULD BE	(0:5) COMPLETION DATE
W 124	the time of the survice Client #1's treatment and potential side of proposed medication treatment, were explained authorized of the review of Client Assessment dated the was not able to	ration had been obtained. At rey, there was no evidence that rit needs, including the benefits effects associated with refuse plained fully to the client or a	<b>W</b> 1	124				
<b>W</b> 130	treatment plans or in give informed consists informed consists. It should be noted to survey April 26, 200 the Qualified Menta (QMRP) was able to #1's use of psychoto January 19, 2007. It should be further one of Client #1's bapproximately 12:4 received a phone conference to the use indicated that he resuse of psychotropic 483,420(a)(7) PRO	inancial affairs and can not ents.  that on the last day of the 17 at approximately 2:30 PM, 18 Retardation Professional produce consents for Client ropic medications dated  noted that an interview with rothers on April 27, 2007 at 18 PM revealed that he call from the facility this week in a of Seroquel. The brother exently signed consents for the	<b>W</b> 1	30				
-	The facility must en Therefore, the facility treatment and care  This STANDARD is Based on observations.	sure the rights of all clients. y must ensure privacy during	-		. ;			

REALIN RESULTATION APPLIA

UD/U8/ZUU/ U9:ZU FAA ZDZ4428401

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PRINTED: 05/07/2007 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING B. WING 04/26/2007 09G074 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 4012 LEE STREET. NE WASHINGTON, E.C. 20019 MÍS PROVIDER'S PLAN OF CORRECTION (X4) COMPLISTION DATE SUMMARY STATEMENT OF DEFICIENCIES FACH CORRECTIVE ACTION SHOULD BE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) W 130 Continued From page 3 W 130 clients' right for privacy during medical and W130 personal care needs for two of three clients residing in the facility. (Client #2 and #3) Using the guideline placed in the MAR book, the DON and the Coordinating RN provided reinforcing training to the medication nurse who failed to protect The findings include: the privacy of the consumer during medication passing (see: attached signature sheet). Nursing and the QMRP 1. The facility failed to ensure that Client #2 will monitor medication administration to insure that received privacy during the evening medication all guideline steps are routinely followed...4-27-07. administration. During the evening medication administration observation at approximately 6:59 PM on April 24, 2007, the Licensed Practical Nurse (LPN) was observed administering medications to Client #2 in the basement. At the time, clients and staffs were in the basement socializing and watching television. The facility failed to ensure that Client #3 received privacy during the evening medication administration. During the evening medication administration observation at approximately 6:59 PM on April 24, 2007, the Licensed Practical Nurse (LPN) was observed administering medications to Client #3 in the basement. At the time, clients and staffs were in the basement socializing and watching

W 159

483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL

Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional.

This STANDARD its not met as evidenced by: Based on observation, interview and record

W 159

Facility ID: 09G074

If continuation sheet Page 4 of 9

television.

MTS, Inc.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES MADE & MEDICAID SERVICES

PRINTED: 05/07/2007 FORM APPROVED OMB NO. 0938-0391

CENTERS FOR MEDICARE (\$ N TATEMENT OF DEFICIENCIES IND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	2) MULTIPLE CONSTRUCTIC N BUILDING			-	(X3) DATE SURVEY COMPLETED 04/26/2007	
		09G074	B. WI	B. WING					
NAME OF PROVIDER OR SUPPLIER.  M T S				4	012 LEE :	RESS, CRY, ST. STREET, NE GTON, C.C. 2	ATE, ZIP CODE		
(X4) ID PREFIX TAG	* . ー・ヘ・・・・・・・・・・・・・・・・・・・・・・・・・・・・・・・・・・	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(E	EACH COF RECT OSS-REFERENC	LAN OF CORRE TIVE ACTION SH SED TO THE API EFICIENCY)	OULD BE	(X8) COMPLETION DATE
W 159	Continued From pa	age 4	. w	159				· .	· · · · · · ·
	client's active treat	ailed to ensure that each ment program was atted and monitored by the etardation Professional			W159	· 	<u>-</u>	· · · · · · · · · · · · · · · · · · ·	,
•	(QMRP).				1.	See responses			
	The findings included in the QMRP fails privacy during treatness. [See W130]	ed to ensure each client's trnent and care of personal			2. 3.	reflect the reco	sheets" have beent change in ac	Idress4-28-	
	employee had bee	en to ensure that each in provided with adequate es the employee to perform his tively, efficiently and b W189]			accurate a	and current via	hat all such info monthly record findings5-1-0	andite and	
	conducted on April 3:30 PM revealed been living in this	he facility's House Manager 1 24, 2007 at approximately that Clients #1, #2, and #3 had new location for about a month nt #1, #2, and #3's records on		-		·	·		
	April 25, 2007 at 1 "Contact Sheet" ic medical records, s on them, Interview	:: 9 PM revealed that the scated in the front of their still had the old addresses listed w with Qualified Mental scional (OMRP) on April 26.				,			
	that the old inform	afely 2:40 PM, acknowledged action had not been updated.					•		
144.400	Contact sheet; the QMRP on the last	that Client #1's nformation was not listed on the information was added by the that of the survey April 26,  AFF TRAINING PROGRAM		/ 18:	9				
W 189		provide each employee with				, 			

PATEMENT OF DEFICIENCIES			1		CONSTRUCTION	(X3) DATE ( COMPL	SURVEY ETED
D PLAN OF CORRECTION IDENTIFICATION NUMBER:			A. BUIL B. WIN				
` .		09G074					<u> 26/2007</u>
ME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP ( LEE STREET, NE	CODE	
TS			1	WAS	HINGTON, DC 20019		
(X4) ID PREFIX TAG	マー・カリ ちきごろばいた	A? EMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDE R'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-RÉFE LENCED TO TH DEFICIENCY	ON SHOULD BE LE APPROPRIATE	(2/5) COMPLETION DATE
N 189.	initial and continuit	ng training that enables the non his or her duties effectively,	<b>W</b> *	189			
	Based on observa review, the facility continuing training employee to enable	•		clien colle occu	QMRP retrained the one-to-on at #1 to insure that she underst ect seizure data at the day prog arred and not later. The QMRI	gram as seizures Provided the staff ssary forms to	, 
	Observations cond April 25, 2007 at a revealed that Clien seizure lasting about the client's one to keeps records of they last in her he that she records to back to the facility	ducted at the day program on approximately 11:00 AM, at #1 was observed having a but 30 seconds. Interview with one staff revealed that "she seizure activity and how long ad". The staff further indicated the seizures when she returns on seizure observations forms.		colle trave	ther with a book and the free- ect the data at the day program els to the day program and bas y basis5-1-07.	1. I BE DOOK HOW	ne
-	Professional (QM conducted on Apr 1:30 PM, revealed all seizures and the documented on the Record verification approximately 2:30 Activity Form to design and the conducted approximately 2:30 Activity Form to design and the conducted approximately 2:30 Activity Form to design and the conducted approximately 2:30 Activity Form to design and the conducted approximately 2:30 Activity Form to design and the conducted approximately 2:30 Activities and the conducted approximately 2:30 Activities approximately 2:30 Act	Clualified Mental Retardation RP) and Registered Nurse il 26, 2007 at approximately il that nurse should be notified of seizure should be seizure observation forms in on the same day at 25 PM revealed a Seizure occument seizure activity utilizing vation form and notify the facility				· · · · · · · · · · · · · · · · · · ·	

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DEPART	MENT OF HEALTH	AND HUMAN SERVICES			·	OMB NO.	0938-0391
CENTER	S FOR MEDICARE OF DEFICIENCIES F CORRECTION	& MEDICAID SERVICES  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI		E CONSTRUCTIC N	(X3) DATE S COMPLE	URVEY ETED
		09G074	B. WIN	IG		04/2	6/2007
NAME OF P	ROVIDER OR SUPPLIER			40	ET ADDRESS, CITY, STATE, ZIP ( 12 LEE STREET, NE	DE	•
MTS		<u> </u>		W	ASHINGTON, I.C. 20019		1 000
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W 189	26, 2007 at approx	cimately 12:30 PM, revealed	W	189			
	had occurred on A observation sheet training records or approximately 2:0	Further review of the staff					
W 212	effective. 483.440(c)(3)(i) 1N	NOIVIDUAL PROGRAM PLAN	w	212		)	
·	identify the preser and where possib	nting problems and disabilities le, their causes.			W212		
	Based on observative review the facility intermittent Exploration	is not met as evidenced by: ations, interview and record failed to include the diagnosis of sive Disorder for a client tion for the condition for one of the sample (Client #1).  des:	f		The coordinating RN made a had modification on the physician' insure that they reflected the II modified orders were sent to the instructions to add the diagnost as of next month5-1-07.  Nursing audits all new physicions basis and will monitor for such with the May 2007 reviews	s orders of client #1 ED diagnosis. The he pharmacy with sis to the orders forn ians' orders on a rou h omissions beginni	nally
	administration on review of the Med (MAR) revealed 200 mg two (2) to with the Register client receives the behaviors. Reviews	the evening medication April 24, 2007 at 7:13 PM and dication Administration Record that Client #1 receives Seroquel ablets two times a day. Interviewed Nurse (RN) revealed that the is medication for his explosive ew of the Physician's Order (PO) onth of April 2007 on April 26, nately 2:05 PM, revealed the					

medication was for behaviors. Further review of

the PO sheets revealed that "intermittent Explosive Disorder (IED)" was not included as a

current diagnosis. On April 26, 2007 at

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1002/00/60	42:60	$\Gamma \Lambda \Lambda$	とひとせせたりせい」

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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PRINTED: 05/07/2007

FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CUA (X2) MULTIPLE CONSTRUCTIC V (X3) DATE SURVEY IDENTIFICATION NUMBER: AND PLAN OF CORRECTION COMPLETED A. BUILDING B. WING 09G074 04/26/2007 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4012 LEE STREET, NE MTS WASHINGTON, CC 20019 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETION (EACH COF RECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PRÉFIX PREFIX TAG TAG DATE DEFICIENCY) W 212 Continued From page 7 W 212 approximately 2:15 PM, the facility's RN acknowledged that the diagnosis was not included in the current physician's orders. The surveyor observed that the RN added Client #1's diagnosis of IED on the physician's order on the last day of the survey. W 263 483.440(f)(3)(ii) PROGRAM MONITORING & W 263 CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal quardian. W263 This STANDARD is not met as evidenced by: See responses for W124. Based on observation, staff interview and record review, the facility failed to ensure that each client's behavior intervention technique, including the use of behavior modification drugs was conducted with the written informed consent of the client, parents (if the client is a minor) or legal guardian for one of two clients included in the sample. (Client #1) The finding includes: Observations of the evening medication administration on April 24, 2007 at 7:13 PM and review of the Medication Administration Record (MAR) revealed that Client #1 receives Seroquel 200 mg two (2) tablets two times a day. Interview with Registered Nurse, Qualified Mental Retardation Professional (QMRP) and the review of the client's PO's revealed the aforementioned medication was used in conjunction with the Behavior Management Plan (BMP) to address

maladaptive behaviors. At the time of the survey,

DEPART	MENT OF HEALTH	I AND HUMAN SERVICES & MEDICAID SERVICES				FORM	: 05/07/2()07 APPROVED : 0938-0391
TATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER:		(X2) M A. BUII	•	PLE CONSTRUCTICIN	(X3) DATE S COMPLI		
		09G074	B. WIA	4G		04/2	26/2007
NAME OF P	ROVIDER OR SUPPLIER			ľ	EET ADDRESS, CITY, STATE, ZIP COD	Ė	
MTS				1	012 LEE STREET, NE /ASHINGTON, D.C. 20019		·
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W 263	Continued From pa	nge 8	W 2	263		•	
	home and at the da	lose supervision in the group by program to protect his health he severity of his seizures.					
	2007 at approximate Client #1's brothers	d with the QMRP on April 25, tely 3:30 PM revealed that are actively involved in his are not his legal guardian.		1			
	dated June 20, 200 able to make indep residential or day p financial affairs and consents. Further interview with the Consent for	's Psychological Assessment 6, indicated that he was not encent decisions concerning lacement, treatment plans or 6 can not give informed review of the record and MMRP failed to evidence that the use of the psychotropic en obtained. At the time of the		p # f	The QMRP will insure that all future asychotropic medication regimen or the are reviewed with his brother and the formal consent is obtained as evidence documentation record5-1-07.	ne BSP for clien hat proper,	ıt
	survey, there was reto refuse medication risk and benefits of included the behave of psychotropic metacility failed to pro-	to evidence that Client's rights ins and to be informed of the behavioral treatment, which ior support plan and the used dications. Additionally, the vide evidence that substituted obtained from a legally					
	approximately 2:30 Retardation Profes produce consents psychotropic medic 2007. Interview wi on April 27, 2007 a revealed that he re this week in referen	he survey April 26, 2007 at PM, the Qualified Mental sional (QMRP) was able to for Client #1's use of cations dated January 19, th one of Client #1's brothers t approximately 12:45 PM ceived a phone call the facility nee to the use of Seroquel, and that he recently signed se of psychotropic medications.					
				-			ŀ.,

Health Regulation Administration

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PRINTED: 05/07/2007 FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (C1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  09G074			A. BUILDI		(X3) DATE SURVEY COMPLETED		
				B. WING_		04/2	6/2007
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1 000	INITIAL COMMEN	rs		1 000			
	24 through April 26 initiated using the fit however, it was det should be extended Client Protection. A clients was selected of three males with disabilities. Two of psychiatric diagnosis prescribed. One clitime of the survey his severe seizure activities.	the clients in the faci es for which medicati ent-randomly selecte ad one to one staffin	vas rocess; vey related to wo opulation lity had ons were d at the g due to				
	observations at the staff interviews at be program, one legal members, review of	residence and day protein the group home a guardian, one family clinical and administine facility's unusual in	ogram, and day rative				
1 090	3504.1 HOUSEKEE	PING		1 090			
	maintained in a safe and sanitary manne	erior of each GHMRF e, clean, orderly, attra r and be free of t, rubbish, and objec	ctive,				
	Based on observation walk-through the Gh	met as evidenced by: on during the environ HNRP failed to maint in, orderly and sanitar e below:	mental ain the				
	The findings include	r.			,		
alth Régula	tion Administration	·	<del> </del>		TELE	·	X8) DATE

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

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If continuation sheet 1 of 5

Health Regulation Administration  STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  09G074		(X2) MULTIPLE CONSTRUCTK IN A. BUILDING B. WING			·	(X3) DATE SURVEY COMPLETED 04/26/2007			
NAME OF P	RESS, CITY,	STATE.	ZIP CODE						
	TIO VIDER DIVIDE I DIE			STREET, N					•
MTS			WASHING	TON, DC 2	0019				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH COF:RECTIVE ACTION SHOULD BE CROSS-REFE RENCIED TO THE APPROPRIATE DEFICIENCY)			OULD BE	(X5) COMPLEITE DATE
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, , , ,	INTERIOR	•		•				,	
	INIERIOR				! <u></u>				ł
	1. The kitchen bac	k door leading to the	back	- 1	3504.1			-	
·	yard was observed	without any window	shades or		1.	The kitchen ba	ck door is now	covered by	
	curtains.		,			shades5-1-07	7.		·.
,	2. The door bell to	cated at the front of t	he house		Ζ.	The front door replaced by5	bell will be rep i-20-07	aired or	
	was observed not t	to be working.			ı		20 07,		
				l 091	'				
1 091	3504.2 HOUSEKE	EPING		1091				·•	ļ
	be well constructed	l maintenance equipr 1, properly maintained function for which it is	dane	-					
	This or wife le not	met as evidenced by	<i>,</i> -						
	Based on observat	tions and interview, tr he interior and exterionate, clean, orderly, at	ne racility or of the						
	The finding include	<b>26</b> :						•	
	Mental Retardation the environmental	nterview with the Quan Professional (QMRI) walk through on Apripately 3:00 PM reved at the front of the fillioning.	r) dunng I 26, 2007 realed that						
1 206	3509.6 PERSONN	IEL POLICIES		1 206				•	
, .	annually thereafter certification that a	rior to employment at r, shall provide a phy- health inventory has at the employee's he r her to perform the r	been aith status						

Health Regulation Administration

MTS.Inc.
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TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPL IDENTIFICATION N			(X2) MULT A. BUILDIN B. WING-		COMPLETED 04/26/290			
NAME OF P	PLAN OF CORRECTION  09G074  E OF PROVIDER OR SUPPLIER  S  4) ID  SUMMARY STATEMENT OF DEFICIENCY MUST BE PRECEDED REGULATORY OR LSC IDENTIFYING INFO	1 0930/4	4012 LEE	DRESS CITY, STREET, N STON, DC 2	ITY, STATE, ZIP CODE T, NE		/ <u>Z0</u> /ZUU/	
(X4) ID PREFIX TAG	(FACH DEFICIENC)	/ MUST BE PRECEDED BY	FULL	ID PREFIX TAG	PROVIDE R'S PLAN OF CO (EACH COFIRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETE DATE	
1 227	This Statute is not Based on record rehave on file for revifor all employees.  The finding include Review of the persethe GHMRP failed certification for the 1. Residential Cou 2. Pharmacist - Co 3510.5(d) STAFF TEach training programmeted to, the follow (c) Infection control This Statute is not Based on record rehave on file for reviand CPR for employment of the finding include On April 26, 2007 records/training recounselor (Staff #1)	met as evidenced by view, the GHMRP farew current health ceres.  connel files on April 26 to provide current health operation - Staff #9 insultant #9  RAINING am shall include, but ving:  for staff and resident met as evidenced by view, the GHMRP farew current training in yees.  s:  eview of personnel cords for one resident did include that he is	iled to rtificates  6, 2007, alth  not be  its; iled to ifirst Aid	1 227	3504.2  See #2 above for 3504.1  3509.6  The pharmacist's health certificate by5-30-07.  Staff member #9's health certific by5-30-07.  MTS audits personnel records queries on the staffing during orient male staff members on the staffing Their CPR training verification is a	ate will be obtained uarterly to insure ctively notify staff of	on.	
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Health F	Regulation Administra	atlon :	<del></del>			·		
STATEMENT OF DEFICIENCIES (X.1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
••		09G074		B. WING	<del></del>	·	045	26/2007
NAME OF F	PROVIDER OR SUPPLIER		STREET ADI	DRESS, CITY,	STATE, ZIP CODE		1	.012007
MTS	<b>\</b>		4012 LEE WASHING	STREET, I	NE 20019			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE  MUST BE PRECEDED BY  SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	(EACH COI)	R'S FLAN OF COR RECTIVE ACTION : RENCED TO THE A DEFICIENCY)	SHOULD RE	(X5) COMPLETE DATE:
1 379	Continued From pa	ge 3 <sub>_</sub>	ļ	I 379				
1 379	3519.10 EMERGEN	NCIES	-	1 379	· .			·
	each GHMRP shall Health, Health Facil unusual incident or interferes with a res arrangement, well be places the resident be made by telephor followed up by written	porting requirement in notify the Department littles Division of any devent which substantident 's health, welfateing or in any other vatrisk. Such notifications immediately and sen notification within urs or the next work of	nt of other tially are, living way tion shall shall be		3519.10  The residential directions of their occurrent track compliance due.			
	Based on interview a GHMRP failed notify	met as evidenced by: and record review the the survey agency on ty-four (24) hours of	e fall	•	track compliance du 07.	ring its monthly n	neetings5-1-	
	The findings include	ć						
	Mental Retardation	nterview with the Qua Professional (QMRP) nusual incident repor ng:	and				÷	
·.	On August 9, 20 was being transporte	06, Resident #2 fell v ed by staff.	vhile he			<i>.</i> `.		
1	under his arm which	06, Resident #2 had a was causing him dis rted to his PCP for fu	comfort.	ļ				
	assisted out of thiba accidentally slipped	06, Resident #3 was lith tub by staff when li and bumped his head on. Resident was tak	ne d. He					

Health Regulation Administration  STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  09G074			A. BUILDING B. WING _		COMPLE	(X3) DATE SURVEY COMPLETED 04/26/2007			
NAME OF P	ROVIDER OR SUPPLIER		4012 LEE	DDRESS, CITY, STATE, ZIP CODE E STREET, NE GTON, DC 20019					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL- REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVID ::R'S PLAN OF C (EACH COI RECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE LE APPROPRIATE	COMPLIETE DATE		
I 379	4. On November 8 feeding Resident #	nge 4 m. He required sutur discharged that sam s, 2006, staff observe 2 some swelling in hi ory of fall or trauma, j velling. Resident was	e day. d while s thumb. ust a	1 379					
	5. On March 8, 20 manager noted a fi rising water. Fire I	07, the provider's factored in the basement Department arrived to power to the home. Assetted to the Ramada	with turn off All three						
•									
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